APPLICATION FOR RESPIRATORY CARE PROFESSIONALS

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
2 PEACHTREE ST NW, 36TH FLOOR
ATLANTA, GA 30303
404-656-3913
www.medicalboard.state.ga.us

I hereby make application for certification pursuant to the Georgia Respiratory Care Practice Act (O.C.G.A. 43-34-140) and submit the following statement concerning my age, moral character, education and practice.

Please type or print legibly.

APPLICANT INFORMATION

Name: Last:_____ First:_____ Middle/Maiden:_____

Mailing Address: _____

_____

Telephone: Home:_____Work:_____

E-Mail Address: _____

Social Security Number: _____ This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A.§ 19-11-1 and O.C.G.A.§ 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information also may be disclosed to the Health Care and Integrity Practitioners Data Bank (HIPDB) or other state medical boards or regulatory agencies for license tracking purposes. If you do not wish this information to be released to the HIPDB or other medical boards or other regulatory agencies for license tracking purposes,

check here ☐

Date of Birth: _____ Place of Birth: _____

If you were born outside of the US, how long have you lived in the US: _____Years _____Months

Are you certified/registered by the National Board of Respiratory Care, Inc? ☐Yes ☐No

Have you served in the US Armed Forces? ☐Yes ☐No

If yes, provide dates of service from: _____ to: _____ and discharge date: _____

Type of discharge: _____ **Attach a copy of your Discharge Form.**

RESPIRATORY CARE AND OTHER HEALTH RELATED LICENSES

Record below the State(s) where you hold or have held a license to practice **Respiratory Care:**

❑ N/A

State	Date License was Issued Month/Year	License Status (Circle One)
		Active Inactive
		Active Inactive
		Active Inactive
		Active Inactive
		Active Inactive
		Active Inactive
		Active Inactive

Record below the State(s) where you hold or have held license to practice **any other** health related profession.

❑ N/A

State	Type of License	Date License was Issued Month/Year	License Status (Circle One)
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive

If you answer "YES" to any of the following questions, you are required to furnish complete details including date, place, reason and disposition of the matter.

		YES	NO
1.	Has any board or agency denied issuance of or pursuant to disciplinary proceeding refused renewal of certificate?	☐	☐
2.	Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven (7) years?	☐	☐
3.	Have you ever been convicted of a violation of any Federal (including military), State or local statue?	☐	☐
4.	Have you ever been denied the privilege to take an examination given by any state licensing board or been denied a certificate/license?	☐	☐
5.	Has any state licensing board revoked or suspended a certificate/license issued to you or taken other disciplinary action?	☐	☐
6.	Have you ever been denied membership in any professional society or association?	☐	☐
7.	Have you ever had any malpractice suits filed against you?	☐	☐
8.	Have you ever voluntarily surrendered any professional license or certificate?	☐	☐
9.	Are you in default on a state or federally funded and/or guaranteed school loan?	☐	☐
10.	To your knowledge, are you the subject of an investigation by any licensing board as of the date of this application?	☐	☐
11.	Have you ever been dismissed or resigned while under investigation at a hospital?	☐	☐
12.	Have you ever defaulted on child support payments?	☐	☐

Date you began working as a Respiratory Therapist in Georgia. _____

Attach a current complete resume.

EDUCATION

HIGH SCHOOL EDUCATION:

School Name: _____

City and State: _____

Dates of Attendance: **From** (month)____(year)_____ **To** (month)_____(year)_____

RESPIRATORY CARE EDUCATION:

School Name: _____

City and State: _____

Dates of Attendance: **From** (month)____(year)_____ **To** (month)_____(year)_____

OTHER EDUCATION: *(Use additional sheets, if necessary)*

☐ N/A

School Name: _____

City and State: _____

Dates of Attendance: **From** (month)____(year)_____ **To** (month)_____(year)_____

Type of Degree Awarded: _____

School Name: _____

City and State: _____

Dates of Attendance: **From** (month)____(year)_____ **To** (month)_____(year)_____

Type of Degree Awarded: _____

AFFIDAVIT OF APPLICANT

I acknowledge and state that I have read and am familiar with the Respiratory Care Practice Act and rules pertaining thereto. I further state that by filing this application for certification as a Respiratory Care Professional in the State of Georgia, I authorize and consent to have an investigation made as to my moral character, profession reputation and fitness to practice as a Respiratory Care Professional. I agree to give any further information that may be required in reference to my past record. I understand that I will not receive a copy of the report or know its contents and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, Federal or foreign) court, association, institution, or any other organization having control of any documents, records or other such information pertaining to me, to furnish to the Composite State Board of Medical Examiners any such documents, records regarding charges or complaints filed against me formal or informal, pending or closed, or any other pertinent data and permit the Georgia Composite State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records or other information, in connections with this application, subsequent to practice there under.

I authorize and request the Georgia Composite State Board of Medical Examiners to obtain any criminal history information concerning me from any authorized law enforcement agency including but not limited to the Georgia Crime Information Center (GCIC) and the (NCIC).

I hereby release, discharge and exonerate the Georgia Composite State Board of Medical Examiners for any and all liability of every nature and kind arising out of the furnishing or inspections of such documents, records or other information or any investigation made by the Georgia Composite State Board of Medical Examiners to release information, material, documents, orders or the like relating to me or to this application to any other agency or any other agency of the State of Georgia, the medical licensing agency of any other state or territory of the United States, or Province of Canada, the Federation of State Medical Boards, or the US Inc., law enforcement agency, hospital or other appropriate agencies as determined by the Board.

This is to certify that the foregoing information is true and correct to the best of my knowledge; I understand that pursuant to the Official Code of Georgia Annotated. Section 43-43-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application, shall be guilty of a felony and upon conviction thereof, shall be punished by paying a fine of not less than $500 nor more than $1000 or by imprisonment from two to five years or both.

Name of Applicant_____

Signature of Applicant_____

Date_____

County_____ State_____

Being duly sworn and says that he/she is the person who executed the above application; and that all statements herein contained are true and that the attached photo is a true photo of the applicant.

Standard Passport Photo

Sworn and subscribed before me,
this ____day_____, 20__

Notary Public_____

Note: Signature and Notary dates should be the same

Notary Public Seal

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
EDUCATION VERIFICATION FORM

Forward this form directly to your Respiratory Therapy Program for completion.

Applicant's Name: _____

Matriculation Date: month/_____ day/_____ year/_____

Type of Program (select only one): ☐ Bachelor's Degree
☐ Associate's Degree
☐ Certificate

This individual will/has complete(d) the program on: month/_____ day/_____ year/_____

Program Director/Registrar's Name *(Please Print)*: _____

Program Director/Registrar's Signature: _____

School Name: _____

City & State of School: _____

Today's Date: month/_____ day/_____ year/_____

School Seal

Please forward this form to the address below:

Composite State Board of Medical Examiners
Respiratory Care
2 Peachtree St. NW, 36th Floor
Atlanta, GA 30303

Temp. Permit No. _____

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
RESPIRATORY CARE REFERENCE FORM

In order for the Composite State Board of Medical Examiners to adequately evaluate the applicant named below for certification to practice as a Respiratory Care Practitioner in the State of Georgia, please complete all pertinent sections in detail. This reference form must be completed and signed by a licensed physician with whom the applicant practices at the time of application. This form must be mailed directly from the physician to:

Composite State Board of Medical Examiners
Respiratory Care
2 Peachtree Street, N.W., 36th Floor
Atlanta, GA 30303

Section 1 (to be completed by applicant):

Name: Last:_____ First:_____ M.I.:____ Maiden: _____

Mailing Address: _____

_____

Telephone Number: _____

Place of Employment or College Clinical:_____

City & State of location indicated above: _____

Section 2 (to be completed by physician or program director, *however*, the medical director must *sign* the form):

Please evaluate the applicant in the following areas:

	Excellent	Good	Average	Poor	Not able to make judgment
Dependability	☐	☐	☐	☐	☐
Quality of Work	☐	☐	☐	☐	☐
Professional Responsibility	☐	☐	☐	☐	☐

Reference Form Continued On Next Page

Date Employment Started month/ day/ year/

In your professional opinion is the applicant capable of performing competently as a Respiratory Care Professional? ☐ Yes ☐ No

Would you recommend certification based on applicant's abilities? ☐ Yes ☐ No
If no, please explain.

I hereby certify that the above applicant is or has been employed under my supervision as a health professional in Respiratory Care *from* (mm/yy)___/___ *to* (mm/yy) ___/___

Applicant worked ☐ full time ☐ part time, approximately _____ hours per week.

Would you rehire (if applicable) ☐ Yes ☐ No? If no, please explain.

Additional Comments:

Name of Business or School

City & State of above location

Physician's Name *(please type or print)*

Physician's Signature

License Number State of Licensure

Business Tel. Number Today's Date

Please Mail to: Composite State Board of Medical Examiners
Respiratory Care Professional
2 Peachtree Street N.W., 36th Floor
Atlanta, GA 30303

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
LICENSURE VERIFICATION FORM

This form should be sent to each state where you hold or have held a license/certificate to practice Respiratory Care. This form may be photocopied.

I am applying for certification under the Respiratory Care Practices Act with the Composite State Board of Medical Examiners. The Georgia Board requires that your Board complete this form in order that I may be considered for certification. By signing this form, I give my consent to release any information, favorable or otherwise, for their review in considering me for a Georgia certificate. As soon as possible, please forward the completed form to the Board at the address listed below.

Section 1 (to be completed by applicant):

My certificate number _____ was issued by your State Board on ___/___/_____ on the basis of

☐NBRC ☐Grandparent Provision ☐Graduation from an approved school

☐Other_____

Name *(Please print or type)* _____

Signature _____

Street Address _____ City, State & Zip Code _____

Section 2 (to be completed by an official of the above referenced Licensing Board):

Respiratory Care Professional Certificate No. _____ to practice as a Respiratory Care Professional in the State of _____ was issued to above-mentioned Respiratory Care Professional on month/_____ day/_____ year/_____.

Is certificate in good standing? ☐Yes ☐No Date license expires (d) (mm/yy) ___/___

Has any disciplinary action ever been taken against the above Respiratory Care Professional including but not limited to suspension or revocation? ☐Yes ☐No
If yes, please furnish details_____

_____

Signed _____

Title _____

State Seal

State Board _____

Date _____

Please Mail to: Georgia Composite State Board of Medical Examiners ▪
Respiratory Care Professional
2 Peachtree Street, N.W., 36th Floor
Atlanta, GA 30303

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
NBRC CREDENTIALS VERIFICATION REQUEST FORM

Complete the information below and submit this form along with the required $5 fee for active members and $20 fee for inactive members.

Send to: NATIONAL BOARD FOR RESPIRATORY CARE
8310 NIEMAN ROAD
LENEXA, KS 66214

I am applying for state licensure in Georgia and I am requesting the NBRC to verify my respiratory therapy credentials directly to:

Georgia Composite State Board of Medical Examiners
Respiratory Care Professional
2 Peachtree Street N.W., 36th Floor
Atlanta, GA 30303

I hold the following NBRC credentials:

☐RRT ☐CPFT ☐Perinatal/Pediatric Specialist

☐CRT ☐RPFT

PRINT NAME UNDER WHICH YOU WERE CREDENTIALED:

Last First Middle Former

Social Security Number

PRINT FULL NAME AND CURRENT ADDRESS:

Last First Middle Former

Street/Apt #

City/State/Zip Code

Business Phone Home Phone

Signature Date